

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010885

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No. 1002

Registrar's No.

1587

STATE FILE NUMBER

FILED APR 5 1962

1. PLACE OF DEATH

a. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN Kansas City

Length of stay in lb

42 Years

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION Long Nursing Home

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Jackson

c. CITY

OR TOWN Kansas City

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

(If outside, give location)

907 Forest

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First LAWRENCE

Middle

Last DE LUCCHI

4. DATE OF DEATH

Month March

Day 19

Year 1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☒Widowed ☐ Divorced ☐

8. DATE OF BIRTH

11/21/69

9. AGE (last birthday)

92

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Janitor

11. BIRTHPLACE (City and state or country)

Italy

12. CITIZEN OF WHAT COUNTRY

-UNK. USA

13a. FATHER'S NAME

Unk

13b. MOTHER'S MAIDEN NAME

Unk

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

17. INFORMANT

Address

Jackson Co Welfare Kansas City Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

2 days

Conditions, if any, which gave rise to above cause (a), stating the underlying, cause, last.

DUE TO (b)

Arteriosclerosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

11-1-60

to 3-19-62

and last saw her him alive on 3-19-62

Death occurred at

5:00 PM the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

3/22/62

23c. NAME OF CEMETERY OR CREMATORY

St Mary's Cemetery

23d. LOCATION (City, town, or county)

Kansas City Missouri

(State)

24. FUNERAL DIRECTOR

ADDRESS

Sheil Funeral Home K C Mo

25. DATE RECD. BY LOCAL REG.

3-20-62

26. REGISTRAR'S SIGNATURE

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
Frank Paul Lawrence
MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

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23158

9331X

1286-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4954

P. O. Address K.P. Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.